SAN ANTONIO KIDNEY

PATIENT FORM

PATIENT INFORMATION			
First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Home Phone ( )	Work Phone ( )	Cell Phone ( )	
Contact Preference ☐ Home Phone ☐ Work Phone ☐ Cell Phone	May we leave you a message regarding medical care & test results? ☐ Yes ☐ No		
Email	Social Security No	Gender Male ☐ Female ☐	
Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed	Race ☐ American Indian or Alaskan Native ☐ Asian ☐ Black/African American ☐ White ☐ Hawaiian/Pacific Islander ☐ More than one	Ethnicity ☐Hispanic/Latin Descent ☐Not Hispanic/Latin Descent	
Primary Care Physician	Referring Physician		
Reason for your visit today			
Other physicians involved in your care			
Pharmacy Name	Pharmacy Address/Crossroads	Pharmacy Phone ( )	
Occupation	Employer		
Emergency Contact	Emergency Contact Phone ( )	Relationship	

RELEASE OF MEDICAL INFORMATION	☐ **Do not release my information to anyone**	
Name	Phone ( )	Relationship
Name	Phone ( )	Relationship

INSURANCE INFORMATION		
Primary Insurance Company	Insurance Company Address	
Policy Holder Name	Policy Holder Date of Birth	Policy Holder Employer
Identification Number	Group/Policy Number	
Secondary Insurance Company	Insurance Company Address	
Policy Holder Name	Policy Holder Date of Birth	Policy Holder Employer
Identification Number	Group/Policy Number	

PAST MEDICAL HISTORY (Check all that apply; fill in dates where appropriate)

Kidneys/Bladder/Prostate

- ☐ Frequent Urinary Tract Infections (>2-3/year)
- ☐ Episodes of Pyelonephritis (Kidney Infection)
- ☐ Kidney Stones
- ☐ Enlarged Prostate
- ☐ History of Acute Kidney Failure, Date: _____
- ☐ Blood in the Urine, Date: _____
- ☐ Protein in the Urine, Date: _____
- ☐ Incontinence
- ☐ Overactive Bladder
- ☐ Kidney Cysts/Polycystic Kidneys

Head, Ears, Nose, Throat

- ☐ Hearing Loss
- ☐ Vision Loss
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Excessive Dry Eyes
- ☐ Nose Bleeds
- ☐ Nasal Allergies/Congestion
- ☐ Headaches
- ☐ Head Trauma

Cardiovascular

- ☐ Hypertension, Year of Diagnosis: _____
- ☐ Coronary Artery Disease
- ☐ Myocardial Infarction (Heart Attack), Date: _____
- ☐ Congestive Heart Failure
- ☐ Atrial Fibrillation
- ☐ Ventricular Arrhythmias
- ☐ Pacemaker/Defibrillator Placement
- ☐ Peripheral Vascular Disease (poor circulation to legs)
- ☐ Valve Disease:
  - ☐ Aortic ☐ Mitral ☐ Tricuspid ☐ Pulmonary
- ☐ Edema (Swelling)
- ☐ Aneurysm

Lungs

- ☐ Emphysema/Bronchitis/COPD
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Pulmonary Hypertension

Endocrine and Glandular Disorders

- ☐ Diabetes Mellitus, Type: I ☐ II ☐
  - Year of Diagnosis: _____
- ☐ Underactive Thyroid ☐ Overactive Thyroid
- ☐ High Cholesterol
- ☐ Obesity

Gastrointestinal

- ☐ Stomach Ulcer
- ☐ Acid Reflux/Heartburn
- ☐ Diverticulosis/Diverticulitis
- ☐ GI Bleeding
- ☐ Liver Disease/Cirrhosis
- ☐ Hepatitis A ☐ B ☐ C ☐ /Jaundice
- ☐ Pancreatitis
- ☐ Colon Polyps
- ☐ Hemorrhoids

Blood and Oncology

- ☐ Cancer/Tumor, Location: _____
  - Date: _____
  - Chemotherapy? Yes☐ No☐, Radiation? Yes☐ No☐
- ☐ Blood Clots
- ☐ Anemia
- ☐ Blood Transfusion
- ☐ Bleeding Disorder
- ☐ Thrombocytopenia
- ☐ Leukemia/Lymphoma

Musculoskeletal Disorders

- ☐ Arthritis: ☐ Osteoarthritis ☐ Rheumatoid
- ☐ Lupus
- ☐ Gout
- ☐ Low Back Pain
- ☐ Osteoporosis
- ☐ Use of Non-Steroidal Anti-Inflammatories (NSAID)

Skin Disorders

- ☐ Psoriasis
- ☐ Dry Skin
- ☐ Skin Ulcers

Neurologic/Psychiatric

- ☐ Seizures
- ☐ Strokes
- ☐ TIA (Mini-Strokes)
- ☐ Migraines
- ☐ Tremor
- ☐ Neuropathy
- ☐ Vertigo
- ☐ Depression
- ☐ Anxiety or Panic Attacks
- ☐ Bipolar Disorder
- ☐ Excessive Alcohol Use/Alcoholism
- ☐ Illegal Drug Use

PAST SURGICAL HISTORY (Check all that apply and provide dates where possible)

☐ Cholecystectomy (Gall Bladder Removal)
☐ Appendectomy
☐ Tonsillectomy/Adenoidectomy
☐ Reduction of Fracture
☐ Hysterectomy
☐ Mastectomy Left ☐ Right ☐
☐ Cataract Extraction Left ☐ Right ☐
☐ Other (list type and date) _____

☐ Coronary Artery Bypass:
Vessel 1☐ 2☐ 3☐ 4☐ 5☐ 6☐
☐ Leg Bypass Left ☐ Right ☐
☐ Colectomy Partial ☐ Total ☐
☐ Hernia Repair:
Inguinal ☐ Left ☐ Right☐; Incisional ☐, Ventral ☐

_____

_____

ALLERGIES TO MEDICATIONS

Name of Medication (ex: Codeine)	Description of Reaction or Accompanying Symptoms

MEDICATION LIST

Please list all current prescription and over-the-counter (OTC) medications you are currently taking or attach a copy of your current list of medications. Include hormones, birth control pills, vitamins, supplements, calcium, and special dietary aides. Also include medications that have been discontinued in the last 3 months and the date is was discontinued.

Medication Name	**Dosage**	**Frequency**	**Prescribing Doctor**
(e.g. Lisinopril)	(e.g. 40 mg, 20 units)	(e.g. 1 tablet twice a day)	(e.g. Dr. Smith)

FAMILY HISTORY

Relative	Living	Age or Age of Death	List Illnesses and/or cause of death
Mother	Y☐ N☐		
Father	Y☐ N☐		
# Brother ☐ Sister ☐ Child ☐	Y☐ N☐		
# Brother ☐ Sister ☐ Child ☐	Y☐ N☐		
# Brother ☐ Sister ☐ Child ☐	Y☐ N☐		
# Brother ☐ Sister ☐ Child ☐	Y☐ N☐		
# Brother ☐ Sister ☐ Child ☐	Y☐ N☐		
# Brother ☐ Sister ☐ Child ☐	Y☐ N☐		
# Brother ☐ Sister ☐ Child ☐	Y☐ N☐		

SOCIAL HISTORY

Current Occupation: _____

Employer: _____ Hours worked each week: _____

Previous Occupation: _____

Are you disabled? Yes☐ No☐ If so, date and why: _____

Highest Level of Education Completed: _____

Marital Status: Married☐ Single☐ Divorced☐ Widowed☐

Who do you live with? _____

Do you drink alcohol? Yes☐ No☐ If yes, what do you drink? Beer☐ Wine☐ Liquor☐,
How many drinks in average week? _____

Have you quit drinking? Yes☐ No☐ If so, when did you quit? _____ How many drinks in average week? _____

Do you smoke? Yes☐ No☐ If yes, how many packs/day? _____

Have you quit smoking? Yes☐ No☐ If yes, how many packs/day? _____ Age started: _____Age quit: _____

Do you or did you ever smoke cigars, pipes, or chew tobacco? Yes☐ No☐

Do you or did you ever use street drugs (Cocaine, Marijuana, LSD, Speed, IV Drugs, etc.)? Yes☐ No☐

Do you drink coffee or caffeinated sodas frequently (< 2 per day)? Yes☐ No☐ If yes, how much each day? _____

HEALTH MAINTENANCE

☐ Colonoscopy, Date: _____

☐ Flu Vaccine, Date: _____

☐ Mammogram, Date: _____

☐ Pneumonia Vaccine, Date: _____

☐

REVIEW OF SYMPTOMS (check all that apply, clarify below if needed)

General
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Weight gain/loss (> 10 lbs.)
- ☐ Recent Hospitalization
- ☐ Recent Illness
- ☐ Poor Appetite

Skin
- ☐ Rashes
- ☐ Excessive Itching
- ☐ Ulcers on Skin
- ☐ Skin Color Changes
- ☐ Excessive Sweating

Head, Eyes, Ears, Nose, Throat
- ☐ Headaches
- ☐ Blurred Vision
- ☐ Sudden Change in Vision
- ☐ Excessively Dry Eyes
- ☐ Frequent Bloody Nose
- ☐ Recurrent Nasal Congestion
- ☐ Ulcers in mouth/lips
- ☐ Dry Mouth

Neck
- ☐ Neck Mass
- ☐ Neck Swelling
- ☐ Swollen Glands

Lungs
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Chronic Cough
- ☐ Bloody Sputum

Heart
- ☐ Chest Pain
- ☐ Swelling of Feet
- ☐ Irregular Heart Beat
- ☐ Cramps in Legs with Walking
- ☐ Heart Murmurs
- ☐ Fainting or Passing Out
- ☐ High Blood Pressure
- ☐ Excessively Low Blood Pressure
- ☐ Heart Stent
- ☐ Pacemaker
- ☐ Wake up at Night Short of Breath
- ☐ Short of Breath Lying Flat in Bed

Stomach/Intestines
- ☐ Abdominal Pain
- ☐ Blood in Stool
- ☐ Black Tarry Stools
- ☐ Nausea &/or Vomiting
- ☐ Diarrhea
- ☐ Frequent Heartburn
- ☐ Jaundice
- ☐ Polyps

Kidneys/Bladder
- ☐ Blood in the Urine
- ☐ Urgency or Overactive Bladder
- ☐ Burning or Pain with Urination
- ☐ Urinate frequently (more than usual)
- ☐ Flank Pain
- ☐ Hesitancy or incomplete emptying
- ☐ Incontinence
- ☐ Excessive Urination at Night
- ☐ Foamy Urine

Men
- ☐ Problems with Erections
- ☐ Weak or Slow Urinary System

Women
- ☐ Lump or Mass in Breast
- ☐ Nipple Discharge
- ☐ Excessive Menstrual Bleeding

Muscles/Joints/Bones
- ☐ Frequent Gout Attacks
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Joint Swelling
- ☐ Muscle Pain
- ☐ Muscle Weakness

Nerves/Brain
- ☐ Numbness or Tingling
- ☐ Dizziness or Vertigo
- ☐ Seizures
- ☐ Tremors or Shaking
- ☐ Memory Loss
- ☐ Balance Problems/Falls

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Insomnia/Trouble Sleeping

Endocrine/Glands
- ☐ Thyroid Problems
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Excessive Thirst

Blood/Lymph Nodes
- ☐ Anemia/Low Blood Count
- ☐ Easy Bruising
- ☐ Easy Bleeding
- ☐ Enlarged Lymph Nodes

Explanation: _____

SAN ANTONIO KIDNEY

PATIENT AUTHORIZATION FORM

RELEASE OF MEDICAL INFORMATION	INITIALS
I authorize San Antonio Kidney to release or disclose any protected health information about me to carry out treatment, payment and healthcare operations.	

CONSENT OF TREATMENT	INITIALS
I authorize the health care providers at San Antonio Kidney to perform a physical examination and provide me (or the patient I represent) any medical treatment deemed necessary.	

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF INSURANCE BENEFITS	INITIALS
I understand I am ultimately responsible for payment on my account. I understand it is my responsibility to provide insurance information, to include any changes, to San Antonio Kidney. I understand I am responsible for any referral or authorizations that my insurance may require and for any charges not covered by my insurance, to include co-payments, deductibles and coinsurance. I authorize payment of benefits to be paid directly to San Antonio Kidney. I understand I am financially responsible for any balances and charges not covered by this assignment.	

NOTICE OF PRIVACY PRACTICES	INITIALS
I acknowledge San Antonio Kidney has provided me a copy of the Notice of Privacy Practices which explains how my Protected Health Information (PHI) may be used and/or disclosed.	

Print Patient Name

Signature of Patient or Legal Representative

Date

SAN ANTONIO KIDNEY

RECORDS RELEASE REQUEST

PATIENT INFORMATION				
First Name	Last Name	MI	Social Security Number	Date of Birth
Address	City	State	Zip	

I hereby authorize and request the following doctor/facility release the below checked items to San Antonio Kidney:

☐ My complete medical record

☐ Records of care from timeframe: _____ to _____ only

☐ Records of care concerning the following condition(s): _____

_____ _____

Patient Signature Date

RECORDS RELEASE FROM:			
Doctor/Facility			
Address	City	State	Zip
Phone Number ( )	Fax Number ( )		

RECORDS RELEASE TO: San Antonio Kidney

☐ 6700 Randolph Blvd	San Antonio	TX	78211	P (210) 654-7326	F (210) 590-8232
☐ 1410 E. Walnut St	Seguin	TX	78155	P (830) 549-5022	F (830) 433-4460
☐ 222 Sidney Baker South, Ste 208	Kerrville	TX	78028	P (830) 896-7607	F (830) 896-8482
☐ 2391 NE Loop 410, Ste 405	San Antonio	TX	78217	P (210) 654-7326	F (210) 590-8232
☐ 2660 E. Common St, Ste 201	New Braunfels	TX	78130	P (830) 620-4650	F (830) 620-4657
☐ 3124 Sidney Brooks, #570B2	San Antonio	TX	78223	P (210) 337-4911	F (210) 337-7749
☐ 400 Baltimore	San Antonio	TX	78215	P (210) 228-0743	F (210) 228-9749
☐ 495 10th Street, Ste 102	Floresville	TX	78114	P (830) 216-2606	F (830) 216-4037
☐ 18707 Hardy Oak Blvd, Ste 530	San Antonio	TX	78258	P (210) 495-8280	F (210) 481-3116
☐ 4330 Medical Dr, Suite 105	San Antonio	TX	78229	P (210) 692-7228	F (210) 692-9671
☐ 10010 Rogers Crossing, Ste 210	San Antonio	TX	78251	P (210) 549-3524	F (210) 549-3526

SAN ANTONIO KIDNEY

Please Send Signed Consent to: Fax – (210) 481-7453, Email – medicalrecords@sakdc.com, or
Mail to; San Antonio Kidney, 7142 San Pedro Ave., Ste. 120, San Antonio, TX 78216

San Antonio Kidney
Telemedicine Consent

Patient Name: _____

Account Number: _____

Date of Birth: _____.

I. Introduction. Telemedicine involves the real-time evaluation, diagnosis, consultation on, and treatment of a health condition using advanced telecommunications technology, which may include the use of interactive audio, video, or other electronic media. As such, telemedicine allows the provider to see and communicate with the patient in real-time.

II. Consent for Treatment. I voluntarily request San Antonio Kidney Physician(s), Nurse Practitioners, and other health care providers as they may deem necessary participate in my medical care through the use of telemedicine.

I understand that San Antonio Kidney Providers (i) may practice in a different location than where I present for medical care, (ii) may not have the opportunity to perform an in-person physical examination, and (iii) rely on information provided by me. I acknowledge that San Antonio Kidney Providers' advice, recommendations, and/or decision may be based on factors not within their control, such as incomplete or inaccurate data provided by me or distortions of diagnostic images or specimens that may result from electronic transmissions. I acknowledge that it is my responsibility to provide information about my medical history, condition and care that is complete and accurate to the best of my ability. I understand that the practice of medicine is not an exact science and that no warranties or guarantees are made to me as to result or cure.

If San Antonio Kidney Providers determine that the telemedicine services do not adequately address my medical needs, they may require an in-person medical evaluation. In the event the telemedicine session is interrupted due to a technological problem or equipment failure, alternative means of communication may be implemented or an in-person medical evaluation may be necessary. If I experience an urgent matter, such as a bad reaction to any treatment after a telemedicine session, I should alert my treating physician and, in the case of emergencies dial 911, or go to the nearest hospital emergency department.

III. Release of Information. To facilitate the provision of care and/or treatment through telemedicine, I voluntarily request and authorize the disclosure of all and any part of my medical record (including oral information) to San Antonio Kidney Providers. I understand and agree that the information I am authorizing to be released may include: 1) AIDS/HIV test results, diagnosis, treatment, and related information: 2) drug screen results and information about drug and alcohol use and treatment; 3) mental health information; and 4) genetic information.

I understand that the disclosure of my medical information to San Antonio Kidney Providers, including the audio and/or video, will be by electronic transmission. Although precautions are taken to protect the confidentiality of this information by preventing unauthorized review, I understand that electronic transmission of data, video images, and audio is new and developing technology and that confidentiality may be compromised by failures of security safeguards or illegal and improper tampering.

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents.

_____ _____

Signature of Patient/Responsible Party (Relationship to Patient) Date

Please Send Signed Consent to: Fax – (210) 481-7453, Email – medicalrecords@sakdc.com, or
Mail to; San Antonio Kidney, 7142 San Pedro Ave., Ste. 120, San Antonio, TX 78216

SAN ANTONIO KIDNEY

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Patient Signature Date

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Doctor/Facility			
Address	City	State	Zip
Phone Number ( )	Fax Number ( )		

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☐ 10010 Rogers Crossing, Ste 210	San Antonio	TX	78251	P (210) 549-3524	F (210) 549-3526
☐ 12602 Toepperwein Rd, Ste. 208	Live Oak	TX	78233	P (210) 403-0794	F (210) 646-0042